Washington State Health Care Authority

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Application for Health Care Coverage
(and to find out if you can get help with costs)

Use this application to see what health care coverage you qualify for:

- Free or low-cost health care coverage from Washington Apple Health (Medicaid), including the Apple Health for Kids with premiums also known as Children's Health Insurance Program (CHIP)
- A tax credit that can help you pay your health care premiums for a Qualified Health Plan
- Full-cost private Qualified Health Plan and Qualified Dental Plan

Apply faster online

- Apply faster online at **wahealthplanfinder.org**

Information you will need to apply for yourself and others:

- Social Security numbers (SSN): for any members of your household who have an SSN (not all programs require you to have an SSN)
- Dates of birth for each member of your household
- Foreign passport, "A" number, or other immigration numbers for any household members who are immigrants and are applying for health care coverage
- Income information for all adults and all minors with enough income to require them to file a tax return
- Information about health insurance available to you or your family

Why do we ask for so much information?

We need the following information to determine what health care coverage you qualify for. We will keep the information you provide private as required by law.

Send your completed and signed application to:

Washington Healthplanfinder
PO Box 946
Olympia, Washington, 98507
or Fax 1-855-867-4467
If you don't have all the information we ask for, you can start your application by filling in your name, date of birth, address, and signature and mail it to the address above.

Get help with this application:

- Online: **wahealthplanfinder.org**
- Phone: Call the Customer Support Center at 1-855-WAFINDER (855-923-4633) or 1-855-627-9604 (TTY)
- In person: To get application assistance search for a Navigator or Broker via the customer support link at **wahealthplanfinder.org**.
- Language or disability: To get free help in your language (including an interpreter or translation of printed materials) or a disability accommodation, call 1-855-WAFINDER (855-923-4633) or 1-855-627-9604 (TTY)

Definitions

Premium: The amount you pay each month for your health plan, if any. You must pay your premium to maintain coverage, even if you do not receive any health care services.

Health Insurance Premium Tax Credits: Tax credits used to lower your monthly premium.

Washington Healthplanfinder: An online marketplace for individuals and families in Washington to compare and enroll in coverage and gain access to tax credits, reduced cost-sharing, and public programs such as Washington Apple Health.

Qualified Health Plan: Private health coverage through Washington Healthplanfinder.

Minimum Essential Coverage: This is the type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual and family health insurance policies, job-based coverage, Medicare, Medicaid, Children's Health Insurance Program (CHIP), TRICARE and other coverage that covers the 10 Essential Health Benefits.

Essential Health Benefits: A set of 10 health care services that all plans must cover, like doctor visits, hospital stays, and prescription drugs. Some benefits are free, and some may have co-pays and co-insurance.

Washington Apple Health: The public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington for Medicaid, the Children's Health Insurance Program (CHIP), and other health care programs funded by Washington state.

For people who are self-employed

You can subtract the allowable expenses below from your gross income to get an amount for your net self-employment income. For more information, see “Instructions for Schedule C or Schedule F” at **www.irs.gov.**

Some examples of allowable expenses are:

- Car and truck expenses
- Commissions, fees, and contract labor
- Depletion
- Depreciation
- Employee benefit programs, pension, and profit-sharing plans
- Insurance (except health) and mortgage interest
- Legal and professional services
- Office expenses, rent, and lease
- Property, liability, or business interruption insurance
- Supplies, repairs, and maintenance
- Travel, meals, and entertainment
- Utilities, taxes, and licenses
- Wages

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Health Care Coverage Rights and Responsibilities

In this document:

1. All health care coverage programs

Your rights

Washington Health Benefit Exchange and Health Care Authority must:

Help you read and fill out all requested forms. The Washington Health Benefit Exchange (HBE) administers Washington Healthplanfinder, where you go to apply for and manage your health and dental coverage. For assistance you can contact Washington Healthplanfinder Customer Support Center at 1-855-923-4633. If you are an individual who is aged, blind or disabled or in need of long-term services and supports (LTSS) you can contact the Department of Social and Health Services (DSHS) at 1-877- 501-2233.

Provide interpreter or translator services at no cost to you and without delay when communicating with HBE, Health Care Authority (HCA), or DSHS. You can request an interpreter any time you contact us.

Keep your personal information private but we may share some information with other state and federal agencies for purposes of eligibility and enrollment.

Read HBE's Privacy Policy **wahealthplanfinder.org/us/en/privacy-policy.html**.

Give you the opportunity to appeal if you disagree with a determination made by HBE or DSHS that affects your eligibility for health coverage, LTSS, a health plan, health insurance premium tax credits, premium assistance or cost-sharing reductions. By asking for an appeal, your case will be reviewed. You can find more information about HBE's appeals process by visiting **wahbexchange.org/contact-us/appeals** or contacting the Washington Healthplanfinder Customer Support Center at 1-855-923-4633. For information about appeals for DSHS programs, contact DSHS at 1-877-501-2233 or visit your local Home and Community Services Office. You will be scheduled for an Administrative Hearing if the appeal is for a decision on Washington Apple Health (Medicaid) coverage.

Treat you fairly. Discrimination is against the law. HBE and HCA comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. HBE and HCA do not exclude or treat people differently because of their race, color, national origin, age, disability, or sex.

HBE and HCA comply with applicable state laws and do not discriminate on the basis of creed, gender, gender expression or identity, sexual orientation, marital status, religion, honorably discharged veteran or military status, or the use of a trained dog guide or service animal by a person with a disability.

HBE and HCA:

- Provide free aids and services to people with disabilities so they can communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages If you need these services, contact 1-855-923-4633.

If you believe HBE or HCA has failed to provide these services or discriminated in another way you can file a grievance with:

- **Washington Health Benefit Exchange Legal Department**
  ATTN: Legal Division Equal Access/Equal Opportunity Coordinator
  PO Box 1757
  Olympia, WA 98507-1757
  1-855-859-2512
  Fax: 1-360-841-7653
  appeals@wahbexchange.org

- **Health Care Authority Division of Legal Services**
  ATTN: Compliance Officer (ADA/Nondiscrimination Coordinator)
  PO Box 42704
  Olympia, WA 98501-2704
  1-855-682-0787
  Fax: 1-360-507-9234
  compliance@hca.wa.gov

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Washington Health Benefit Exchange Legal Department or the HCA Division of Legal Services are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, by mail, email, phone, or online at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019, 800-537-7697 (TDD)
Email: **ocrmail@hhs.gov**
Online: **ocrportal.hhs.gov/ocr/smartscreen/main.jsf**

Complaint forms are available at: **hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf**

Your responsibilities

You must provide a Social Security Number (SSN) or immigration document number if you have one. If you do not have an SSN or immigration document, you can still apply for health care coverage but may not be eligible for all programs with financial assistance. We use this information to check your eligibility for programs by confirming your identity, citizenship, immigration status, date of birth, and availability of other health care coverage. We do not share this information with any immigration agency. An SSN is required for certain tax credits and programs.

If you do not provide SSN or immigration document number for yourself or someone in your household, we may need to follow up with you for additional information. Provide any information or proof needed to decide if you are eligible, if requested by the agency.

Things you should know

There are certain state and federal laws that govern the operation of Washington Healthplanfinder and state-administered application systems, your rights and responsibilities as someone who uses them and the coverage you get from using them. By using these systems, you agree to comply with the laws that apply to someone using them and the coverage they get as a result.

The National Voter Registration Act of 1973 requires all states to provide voter registration assistance through their public assistance offices. Applying to register or declining to register to vote will not affect your eligibility for coverage or the benefits and services or benefits provided through our agencies. You can register to vote at **vote.wa.gov** or order voter registration forms by calling 1-800-448-4881.

Health Insurance Portability and Accountability Act (HIPAA) restrictions prevent HBE, HCA, and DSHS from discussing the health information of you or any member of your household with anyone, including an authorized representative, unless that individual has power of attorney, or you have signed a consent form authorizing the disclosure of this information. This includes disclosure of mental health information, HIV, AIDS, STD test results, or treatment and chemical dependency services. For more information about HBE's privacy policy, visit **wahealthplanfinder.org/_content/PrivacyPolicy.html**

The Affordable Care Act prevents HBE, HCA, and DSHS from giving personally identifiable information (PII) about you or any member of your household to anyone who is not authorized to receive it, and without your consent.

The information that you give HBE, HCA, and DSHS is subject to verification by federal and state officials for purposes of determining your eligibility for health care coverage. Verification can include post-eligibility reviews and follow up from agency staff.

If you begin an application for health insurance through Washington Healthplanfinder and do not complete the process for any reason, your information will be stored in Washington Healthplanfinder and accessible by you for 90 days. If you do not complete the application after the 90-day period, your information will be deleted from the Washington Healthplanfinder system.

HBE, HCA, and DSHS are not responsible for administering your health insurance plan. Your health insurance carrier can provide you more information about your benefits.

If you have questions about the terms of your health insurance plan, including what benefits you are eligible for, out of pocket expenses under your plan, and making a benefit claim or appealing a denial of benefits, you should contact your health insurance carrier. If you are eligible for COBRA following the termination of any health insurance coverage purchased through Washington Healthplanfinder, administering COBRA and providing you the required COBRA notices and election periods is your employer's responsibility.

Do not cancel any current insurance coverage or decline any COBRA benefits until you receive an approval letter and insurance policy, also known as insurance contract or certificate, from the insurance carrier you selected. Make sure you understand and agree with the terms of the policy, pay special attention to the effective date, waiting periods, premium amount, benefits, limitations, exclusions, and riders.

2. Washington Apple Health only

Your rights

Washington Health Benefit Exchange and Health Care Authority must:

Explain to you your rights and responsibilities if you ask.

Allow you to submit a partial application that includes at minimum, your name, address, and signature or the signature of the applicant's authorized representative. The day we get a partial application is your application date, which may affect when your coverage becomes effective. We will not make a final decision about your coverage until after you complete the application.

Allow you to apply or submit a partial application using any method listed under WAC 182-503-0005.

Process your application promptly and no later than the timelines described in WAC 182-503-0060.

Give you 10 calendar days we need to determine eligibility. If you ask for more time, we will give you more time. If you do not give us the information or ask for more time, we may deny, close, or change your health care coverage.

Help you if you have trouble getting any information or proof needed for us to decide if you are eligible. If we require a document that will cost you money, we will send for it and pay the cost.

Notify you, in most cases, at least 10 days before we stop your health care coverage.

Give you a written eligibility decision, in most cases, within 45 days. Health care coverage for some disability cases may take up to 60 days. We give a written decision on pregnancy medical within 15 days.

Allow you to refuse to speak to an investigator if we audit your case. You do not have to let an investigator into your home. You may ask the investigator to come back at another time. Such a request will not affect your eligibility for health care coverage.

Continue Washington Apple Health coverage while we decide if you are eligible for another program per WAC 182-504-0125

Give you equal access services as described in WAC 182-503-0120 if you are eligible.

Your responsibilities

You must:

Report changes as required in WAC 182-504-0105 and WAC 182-504-0110 within 30 days of the change. Read your approval letter to see what changes you must report.

Complete renewals when asked.

Give medical providers information needed to bill us for health care services.

Apply for Medicare if you are entitled to it.

Cooperate with HCA staff when asked.

Things you should know

By asking for and receiving Apple Health, you give the state of Washington all rights to any medical support and to any third-party payments for health care.

- **The Agency may share** your child's immunization history with the Child Profile Immunization Tracking System.
- **Information you report** may be provided to DSHS to determine eligibility and monthly benefits for programs such as health care coverage, cash assistance, food assistance and child care subsidies.

By law, the State of Washington may recover the costs it paid for certain types of medical services from your estate through Estate Recovery (RCW 41.05A.090, RCW 43.20B.080, and Chapter 182-527 WAC). Estate Recovery doesn't happen until after your death, the death of your surviving spouse, and your surviving children are age 21 or older. It also doesn't happen if a surviving child was blind/disabled at your time of death. Recoverable costs include:

- Certain Washington Apple Health long-term services and supports, if you're age 55 or older at the time you received the services;
- Certain state-only funded services, regardless of your age at the time you received the services.

You can find a list of services subject to cost recovery under WAC 182-527-2746. You can find a list of assets excluded from recovery under WAC 182-527-2754. The State may also file a pre-death lien for recovery after death, subject to requirements of 42 U.S. Code 1396p. Tribal lands and certain properties belonging to American Indians and Alaska Natives may be exempt from recovery (WAC 182-527-2754). The State may recover from a sale of the property, or your estate, unless:

- Your spouse lives at the property;
- Your sibling lives at the property, is a co-owner, and meets certain conditions.
- Your child lives at the property, and is blind/disabled; or
- Your child lives at the property and is younger than age 21.

You can find a list of services subject to cost recovery under a pre-death lien in WAC 182-527-2734.

You may be restricted to one health care provider, pharmacy, and/or hospital if you seek out unnecessary health care services from providers.

3. Qualified Health Plans only

Things you should know

If you enroll in a qualified health plan through Washington Healthplanfinder and do not provide enough information to verify your eligibility, you will have 90 days to provide further information to satisfy eligibility requirements. Any advance payments of tax credits paid on your behalf are subject to reconciliation.

If you have a Social Security Number (SSN), you must provide it on your application. If you do not have an SSN , you can still purchase health insurance on Washington Healthplanfinder. We use this information to check if you are eligible for health care coverage by confirming your identity, citizenship, immigration status, date of birth, and availability of other health care coverage. We do not share this information with any immigration agency. An SSN is required for certain tax credits and programs.

If you do not provide a Social Security number for yourself or someone in your household, we may need to follow up with you for additional information.

If you enroll in a qualified health plan through Washington Healthplanfinder and have a change in income, you should notify us as soon as possible. A change in income could change the tax credits or cost-sharing reductions you are eligible for. You could be eligible for a lower-cost plan following a change of income, or you could be required to pay back a portion of a tax credit you receive if your income increases, and you do not report the changes.

You can report a change of income by logging into your Washington Healthplanfinder account and selecting "Report a Change." For assistance, or to notify us by phone, call our Customer Support Center at 1-855-923-4633.

Reconciling tax credits is required: You are required to report the tax credits you receive to the IRS. You do this by filing an annual IRS tax return and including the correct IRS forms. Failure to report tax credits to the IRS will keep you from

receiving tax credits in the future. For more information read the instructions provided with the IRS forms 1095 and 8962.

Health insurance costs shown can change: Costs can change based on the health insurance carrier's underwriting practices and your choice of any available options.

Rates shown are for your requested effective date only. Your premium rate depends on the age of people in your household. If a member in your household has a birthday between the time you review the plan and the time your plan starts (effective date), your premium cost may increase. The carrier you selected may not guarantee their rates for any period of time. Your coverage will not be active until your insurer confirms receipt of payment.

You consent to the Washington State Employment Security Department's release of your wage and employment data to HBE. You acknowledge that granting this consent will help to simplify the application and redetermination process in Washington Healthplanfinder. Your personal information will be protected as described in our Privacy Policy. View HBE's privacy policy at **wahealthplanfinder.org/us/en/privacy-policy.html**.

4. File a Complaint

In accordance with federal law and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discrimination on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, contact HHS.

Regional Manager,
Office for Civil Rights
U.S. Department of Health and Human Services
2201 Sixth Ave. M/S: RX-11
Seattle, WA 98121-1831
Phone: 1-800-368-1019
TDD: 1-800-537-7697
Fax: 206-615-2297

You can also file a civil rights complaint with HHS, Office for Civil Rights.

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[English] Language assistance services, including interpreters and translation of printed materials, are available free of charge. Call 1-800-562-3022 (TRS: 711).

[Amharic] የቋንቋ እገዛ አገልግሎት፣ አስተርጓሚ እና የሰነዶችን ትርጉም ጨምሮ በነጻ ይገኛል። 1-800-562-3022 (TRS: 711) ይደውሉ።

[Arabic] خدمات المساعدة في اللغات، بما في ذلك المترجمين الفوريين وترجمة المواد المطبوعة، متوفرة مجاناً، اتصل على رقم 1-800-562-3022 (TRS: 711).

[Burmese] ဘာသာပြန်ဆိုသူများနှင့် ထုတ်ပြန်ထားသည့် စာရွက်စာတမ်းများဘာသာပြန်ခြင်းအပါအဝင် ဘာသာစကားအထောက်အကူဝန်ဆောင်မှုများကို အခမဲ့ရနိုင်ပါသည်။ 1-800-562-3022 (TRS: 711) ကိုဖုန်းခေါ်ဆိုပါ။

[Cambodian] សេវាជំនួយភាសា រួមមានទាំងអ្នកបកប្រែផ្ទាល់មាត់ និង ការបកប្រែឯកសារបោះពុម្ព គឺអាចរកបានដោយឥតគិតថ្លៃ។ ហៅទូរស័ព្ទទៅលេខ 1-800-562-3022 (TRS: 711)។

[Chinese] 免费提供语言协助服务，包括口译员和印制资料翻译。请致电 1-800-562-3022 (TRS: 711)。

[Farsi (Persian)] خدمات کمک زبانی، از جمله مترجم شفاهی و ترجمه اسناد و مدارک (مطالب) چاپی، بصورت رایگان ارائه خواهد شد.با شماره 1-800-562-3022 (TRS: 711) تماس بگیرید.

[French] Des services d’aide linguistique, dont des interprètes et la traduction des documents, sont disponibles gratuitement. Appelez le 1-800-562-3022 (TRS : 711).

[Korean] 통역 서비스와 인쇄 자료 번역을 포함한 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-562-3022 (TRS: 711)번으로 전화하십시오.

[Laotian] ການບໍຣິການດ້ານພາສາ, ລວມທັ້ງນາຍແປພາສາ ແລະ ການແປເອກສານຕີພິມ, ມີໄວ້ໃຫ້ຟຣີໂດຍບໍ່ຄິດຄ່າ. ໂທຫາເລກ 1-800-562-3022 (TRS: 711).

[Pashto] په انګليسي ژبه باندې دپوهيدلو، په شمول د ژباړونکي او د چاپ شوي موادو ژباړه کولو د مرستې خدمتونه، پرته له تادیي په وړیا توګه شتون لري. دي خدمت ته لاسرسي موندلو لپاره دي شمېرې 1-800-562-3022 ته زنګ ووهئ (د اوریدلو یا خبرو کولو معلولیت لرونکي خلکو د زنګ وهلو شمېره (TRS): 711)

[Portuguese] Serviços de assistência linguística, incluindo interpretação e tradução de versões impressas, estão disponíveis gratuitamente. Ligue para 1-800-562-3022 (TRS: 711).

[Punjabi] ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ—ਦੁਭਾਸ਼ੀਏ ਅਤੇ ਪ੍ਰਿੰਟ ਕੀਤੀ ਹੋਈ ਸਮੱਗਰੀ ਦੇ ਅਨੁਵਾਦ ਸਮੇਤ—ਮੁਫ਼ਤ ਉਪਲੱਬਧ ਹਨ। 1-800-562-3022 (TRS: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

[Russian] Языковая поддержка, в том числе услуги переводчиков и перевод печатных материалов, доступна бесплатно. Позвоните по номеру 1-800-562-3022 (TRS: 711).

[Somali] Adeego caawimaad luuqada ah, ay ku jirto turjubaano afka ah iyo turjumid lagu sameeyo waraaqaha la daabaco, ayaa lagu helayaa lacag la’aan. Wac 1-800-562-3022 (TRS: 711).

[Spanish] Hay servicios de asistencia con idiomas, incluyendo intérpretes y traducción de materiales impresos, disponibles sin costo. Llame al 1-800-562-3022 (TRS: 711).

[Tagalog] Mga serbisyong tulong sa wika, kabilang ang mga tagapagsalin at pagsasalin ng nakalimbag na mga kagamitan, ay magagamit ng walang bayad. Tumawag sa 1-800-562-3022 (TRS: 711).

[Tigrigna] ተርንምትን ናይ ዝተፅሓፉ ማተርያላት ትርጉምን ሓዊሱ ናይ ቋንቋ ሓገዝ ግልጋሎት፤ ብዘይ ምንም ክፍሊት ይርከቡ።
ብ 1-800-562-3022 (TRS: 711) ደውል።

[Ukrainian] Мовна підтримка, у тому числі послуги перекладачів та переклад друкованих матеріалів, доступна безкоштовно. Зателефонуйте за номером 1-800-562-3022 (TRS: 711).

[Vietnamese] Các dịch vụ trợ giúp ngôn ngữ, bao gồm thông dịch viên và bản dịch tài liệu in, hiện có miễn phí. Gọi 1-800-562-3022 (TRS: 711).

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Application for Health Care Coverage
PART 1

1 Primary applicant name and contact information

First name _____ M.I. _____ Last name and Suffix _____

Date of birth (MM/DD/YYYY) _____ Social Security number (SSN)* _____ Sex assigned at birth M F

Signature of applicant or authorized representative _____

Do you have a home address? No Yes

If no, in what county would you like to receive health care services? _____
You still need to provide a mailing address.

Address where you live _____ City _____ State _____ Zip Code _____

Mailing address (if different) _____ City _____ State _____ Zip Code _____

Primary phone number _____ Secondary phone number _____ E-mail address _____

Washington Healthplanfinder may need to contact you regarding the status of your application and/or request additional information. How do you prefer to be contacted? Phone E-mail USPS Mail

***This information is not shared with any immigration agency for immigration enforcement purposes. Leave this blank if you do not have a SSN.**

2 Language information

Do you or anyone you are applying for want an interpreter and to receive documents in a language other than English?

No Yes

If yes, what language or alternative format do you need? List all that apply: _____

Do you or anyone you are applying for need a document in an alternative format? No Yes

If yes, what alternative format should we sent to you? Larger print English Braille

18001

3 Pregnancy information

Is someone in the household pregnant? No Yes

4 Authorized representative information

1. An authorized representative (AREP) is any adult who is sufficiently aware of the household circumstances and is authorized by the household to act on behalf of the household for eligibility purposes. This is different from partnering with a Navigator or a Broker.
2. If an applicant is unable to designate an AREP, due to a medical condition, an individual may self-designate as the AREP by completing the Authorization Representative Designation Form (DSHS 14-532) at **dshs.wa.gov/authorized-rep-form.**
3. By designating an authorized representative, you are giving permission for your authorized representative to:
    - Sign the application on your behalf;
    - Receive notices related to your application and account; and
    - Act on your behalf for all matters related to the application and account.

a. Are you designating an authorized representative? No Yes

b. Do you want your authorized representative to also receive notices related to your application and account? No Yes

Authorized representative name/organization

Phone number

Mailing address of authorized representative

E-mail address

5 Information about your family

You must include these individuals in your application: your spouse, your children who live with you, all parents living in the home with their child, and anyone you expect to claim on your federal income tax return, if you file one. Use pages 9 through 16 to share information about your family.

If you expect to be claimed as a tax dependent on someone's tax return, you must include all members of the tax filing household claiming you and any family members living with you.

You don't need to file taxes to apply for health care coverage.

6 Primary applicant (self)

First name M.I. Last name Date of birth (MM/DD/YYYY)

Is this person applying for health care coverage? No Yes

SELF

Relation to you:

(For individuals not applying for coverage, providing a Social Security number (SSN) or citizenship status is optional)

Citizenship status: (check one)

U.S. citizen or U.S. national Non-citizen lawfully present in the U.S. Other

Social Security number (SSN):

If you are a lawfully present non-citizen, enter the following information:

Immigration document type: "A" number: Receipt number or other number:

Foreign passport number: Country of issuance:

Date of entry: (MM/DD/YYYY) Document expiry date: (MM/DD/YYYY)

Expected tax filing status for the current year (select one)

Single filing taxes

Head of household

Qualifying widow(er) with dependent child

Married filing taxes separately

Married filing taxes jointly:

Name of primary tax filer: _____

Tax dependent of someone on the application

Tax dependent of someone not on the application

Person has neither filed taxes nor was tax dependent

Did you have the same tax filing status last year as the current year listed above? No Yes

If no, list last year's tax filing status: **(Your response to this question does not affect your eligibility for Apple Health)**

If you are submitting this application between 11/01 and 12/31 of this calendar year, do you expect to file with the same tax status next year as you did this year? No Yes

Race (OPTIONAL – check all that apply)

American Indian or Alaska Native

Asian Indian

Black or African American

Cambodian

Chinese

Filipino

Guamanian

Hawaiian

Japanese

Korean

Laotian

Other Asian Pacific Islander

Other Race

Samoan

Thai

Vietnamese

White

Are you Hispanic, Latino, or Spanish origin?

Cuban

Mexican/Mexican-American/Chicano

Not Spanish/Hispanic

Other Spanish/Hispanic

Puerto Rican

Why we collect this – We use this information to help improve health equity and increase access to health care for all individuals. The information you provide will not prevent your ability to enroll in a health plan.

Are you an American Indian or Alaska Native? No Yes

7 Spouse or other parent (if living in the home)

First name _____ M.I. _____ Last name _____ Date of birth (MM/DD/YYYY) _____

Is this person applying for health care coverage? No Yes Sex assigned at birth M F

Relation to you (e.g. spouse, domestic partner, partner) _____

(For individuals not applying for coverage, providing a Social Security number (SSN) or citizenship status is optional)

Citizenship status: (check one)

U.S. citizen or U.S. national Non-citizen lawfully present in the U.S. Other

Social Security number (SSN): _____

If this individual is a lawfully present non-citizen, enter the following information:

Immigration document type: _____ "A" number: _____ Receipt number or other number: _____

Foreign passport number: _____ Country of issuance: _____

Date of entry: (MM/DD/YYYY) _____ Document expiry date: (MM/DD/YYYY) _____

Expected tax filing status for the current year (select one)

Single filing taxes

Head of household

Qualifying widow(er) with dependent child

Married filing taxes separately

Married filing taxes jointly:

Name of primary tax filer: _____

Tax dependent of someone on the application

Tax dependent of someone not on the application

Person has neither filed taxes nor was tax dependent

Did you have the same tax filing status last year as the current year listed above? No Yes

If no, list last year's tax filing status: _____ **(Your response to this question does not affect your eligibility for Apple Health)**

If you are submitting this application between 11/01 and 12/31 of this calendar year, do you expect to file with the same tax status next year as you did this year? No Yes

Race (OPTIONAL – check all that apply)

American Indian or Alaska Native Filipino Laotian Vietnamese

Asian Indian | Guamanian | Other Asian Pacific Islander | White

Black or African American | Hawaiian | Other Race

Cambodian | Japanese | Samoan

Chinese | Korean | Thai

Are you Hispanic, Latino, or Spanish origin?

Cuban | Mexican/Mexican-American/Chicano | Not Spanish/Hispanic

Other Spanish/Hispanic | Puerto Rican

Why we collect this – We use this information to help improve health equity and increase access to health care for all individuals. The information you provide will not prevent your ability to enroll in a health plan.

Are you an American Indian or Alaska Native? No Yes

8 List children / Tax dependents/Other household members #1

First name | M.I. | Last name | Date of birth (MM/DD/YYYY)

Is this person applying for health care coverage? No Yes Sex assigned at birth M F

Relation to you (e.g. child, grandchild, niece, nephew, sibling)

(For individuals not applying for coverage, providing a Social Security number (SSN) or citizenship status is optional)

Citizenship status: (check one)

U.S. citizen or U.S. national | Non-citizen lawfully present in the U.S. | Other

Social Security number (SSN):

If this individual is a lawfully present non-citizen, enter the following information:

Immigration document type: | "A" number: | Receipt number or other number:

Foreign passport number: | Country of issuance:

Date of entry: (MM/DD/YYYY) | Document expiry date: (MM/DD/YYYY)

Expected tax filing status for the current year (select one)

Single filing taxes | Tax dependent of someone on the application

Head of household

Qualifying widow(er) with dependent child

Married filing taxes separately

Married filing taxes jointly:

Name of primary tax filer: _____

Tax dependent of someone not on the application

Person has neither filed taxes nor was tax dependent

Did you have the same tax filing status last year as the current year listed above? No Yes

_____

If no, list last year's tax filing status: **(Your response to this question does not affect your eligibility for Apple Health)**

If you are submitting this application between 11/01 and 12/31 of this calendar year, do you expect to file with the same tax status next year as you did this year? No Yes

Race (OPTIONAL – check all that apply)

American Indian or Alaska Native

Asian Indian

Black or African American

Cambodian

Chinese

Filipino

Guamanian

Hawaiian

Japanese

Korean

Laotian

Other Asian Pacific Islander

Other Race

Samoan

Thai

Vietnamese

White

Are you Hispanic, Latino, or Spanish origin?

Cuban

Mexican/Mexican-American/Chicano

Not Spanish/Hispanic

Other Spanish/Hispanic

Puerto Rican

Why we collect this – We use this information to help improve health equity and increase access to health care for all individuals. The information you provide will not prevent your ability to enroll in a health plan.

Are you an American Indian or Alaska Native? No Yes

9 List children / Tax dependents/Other household members #2

First name	M.I.	Last name	Date of birth (MM/DD/YYYY)

Is this person applying for health care coverage? No Yes Sex assigned at birth M F

_____

Relation to you (e.g. child, grandchild, niece, nephew, sibling)

(For individuals not applying for coverage, providing a Social Security number (SSN) or citizenship status is optional)

Citizenship status: (check one)

U.S. citizen or U.S. national Non-citizen lawfully present in the U.S. Other

_____

Social Security number (SSN):

If this individual is a lawfully present non-citizen, enter the following information:

_____ _____ _____

Immigration document type: "A" number: Receipt number or other number:

_____ _____

Foreign passport number: Country of issuance:

_____ _____

Date of entry: (MM/DD/YYYY) Document expiry date: (MM/DD/YYYY)

Expected tax filing status for the current year (select one)

Single filing taxes

Head of household

Qualifying widow(er) with dependent child

Married filing taxes separately

Married filing taxes jointly:

Name of primary tax filer: _____

Tax dependent of someone on the application

Tax dependent of someone not on the application

Person has neither filed taxes nor was tax dependent

Did you have the same tax filing status last year as the current year listed above? No Yes

_____

If no, list last year's tax filing status: **(Your response to this question does not affect your eligibility for Apple Health)**

If you are submitting this application between 11/01 and 12/31 of this calendar year, do you expect to file with the same tax status next year as you did this year? No Yes

Race (OPTIONAL – check all that apply)

American Indian or Alaska Native

Asian Indian

Black or African American

Filipino

Guamanian

Hawaiian

Laotian

Other Asian Pacific Islander

Other Race

Vietnamese

White

Cambodian Japanese Samoan

Chinese Korean Thai

Are you Hispanic, Latino, or Spanish origin?

Cuban Mexican/Mexican-American/Chicano Not Spanish/Hispanic

Other Spanish/Hispanic Puerto Rican

Why we collect this – We use this information to help improve health equity and increase access to health care for all individuals. The information you provide will not prevent your ability to enroll in a health plan.

Are you an American Indian or Alaska Native? No Yes

10 List children / Tax dependents/Other household members #3

First name M.I. Last name Date of birth (MM/DD/YYYY)

Is this person applying for health care coverage? No Yes Sex assigned at birth M F

Relation to you (e.g. child, grandchild, niece, nephew, sibling)

(For individuals not applying for coverage, providing a Social Security number (SSN) or citizenship status is optional)

Citizenship status: (check one)

U.S. citizen or U.S. national Non-citizen lawfully present in the U.S. Other

Social Security number (SSN):

If this individual is a lawfully present non-citizen, enter the following information:

Immigration document type: "A" number: Receipt number or other number:

Foreign passport number: Country of issuance:

Date of entry: (MM/DD/YYYY) Document expiry date: (MM/DD/YYYY)

Expected tax filing status for the current year (select one)

Single filing taxes

Head of household

Qualifying widow(er) with dependent child

Married filing taxes separately

Tax dependent of someone on the application

Tax dependent of someone not on the application

Person has neither filed taxes nor was tax dependent

Married filing taxes jointly:

Name of primary tax filer: _____

Did you have the same tax filing status last year as the current year listed above? No Yes

_____

If no, list last year's tax filing status: **(Your response to this question does not affect your eligibility for Apple Health)**

If you are submitting this application between 11/01 and 12/31 of this calendar year, do you expect to file with the same tax status next year as you did this year? No Yes

Race (OPTIONAL – check all that apply)

American Indian or Alaska Native	Filipino	Laotian	Vietnamese
Asian Indian	Guamanian	Other Asian Pacific Islander	White
Black or African American	Hawaiian	Other Race	
Cambodian	Japanese	Samoan	
Chinese	Korean	Thai	

Are you Hispanic, Latino, or Spanish origin?

Cuban	Mexican/Mexican-American/Chicano	Not Spanish/Hispanic
Other Spanish/Hispanic	Puerto Rican	

Why we collect this – We use this information to help improve health equity and increase access to health care for all individuals. The information you provide will not prevent your ability to enroll in a health plan.

Are you an American Indian or Alaska Native? No Yes

To include more household members, attach a sheet with information requested for each individual.

11 Information about your household

American Indian & Alaska Native information

American Indian and Alaska Natives may be eligible for special Apple Health protections and for special benefits through Washington Healthplanfinder. Complete the table below for each member you are applying for that is of American Indian or Alaska Native descent.

_____ _____

Name of person Tribe name

Member of a federally recognized tribe, band, Pueblo or Rancheria;

Shareholder in an Alaska Native Regional or Village Corporation No Yes

Name of person Tribe name

Member of a federally recognized tribe, band, Pueblo or Rancheria;

Shareholder in an Alaska Native Regional or Village Corporation No Yes

Name of person Tribe name

Member of a federally recognized tribe, band, Pueblo or Rancheria;

Shareholder in an Alaska Native Regional or Village Corporation No Yes

Name of person Tribe name

Member of a federally recognized tribe, band, Pueblo or Rancheria;

Shareholder in an Alaska Native Regional or Village Corporation No Yes

Residency

A Washington resident is someone who currently resides in Washington, intends to reside in Washington, including individuals without a fixed address; or someone who entered the state with a job commitment or looking for a job.

Is everyone applying for health care coverage a Washington State resident? No Yes

If no, list anyone who is not a resident:

Tobacco use

Has any household member on this application regularly used tobacco products in the past 6 months No Yes

If yes, enter their name:
(Your response to this question does not affect your eligibility for Apple Health)

Adult disabled tax dependent

An adult disabled tax dependent is an individual who is not capable of employment due to a disability and is dependent on a household member for support.

Do you have an adult child who is a disabled dependent 26 years or older? No Yes

If yes, enter their name:
(Your response to this question does not affect your eligibility for Apple Health)

Jail and prison information

1. Are you or anyone you are applying for in jail or prison? No Yes

_____

If yes, enter their name:

2. Are disposition of charges pending? No Yes
3. Is the release date within 30 days? No Yes

Voter registration

If you are not registered to vote where you live now, would you like to apply to register to vote? No Yes

If you select "Yes" you will be provided a voter registration form.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided or your eligibility.

If you would like help in filling out the voter registration application, you can receive assistance at Washington's toll-free voter registration hotline, 1-800-448-4881. The decision whether to seek or accept help is yours. You may fill out an application in private.

If you believe that someone has interfered with your right to register to vote or to decline to register to vote, or your right to privacy in deciding whether to register, you may file a complaint with the Washington State Election Division, PO Box 40229, Olympia, WA 98504, email **elections@sos.wa.gov**, or call 1-800-448-4881.

Signature for Qualified Health Plan applicants

STOP: You could be eligible for free or low-cost coverage. If you don't want your income considered and would like to enroll in a Qualified Health Plan (QHP), sign below and submit your application. You will pay full cost for your health coverage and do not need to complete Part 2 of the application.

I have read or had explained to me my Rights and Responsibilities.

By signing this application, you are agreeing to Washington Healthplanfinder sharing your information with other state and federal agencies.

_____ _____

Signature Date

CONTINUE: To apply for Washington Apple Health (Medicaid) or tax credits to lower your insurance premium, you must complete Part 2 of this application.

PART 2

1 Health insurance information

Do you or anyone you are applying for have health insurance coverage other than Washington Apple Health (Medicaid or CHIP)?

(Examples include private or employer insurance, Individual health insurance, Limited benefit insurance, Medicare, Veterans,

Peace Corps, Tri-Care, and other insurance) No Yes

If yes, provide the information in the table below. If more than one person has other insurance, use additional paper.

Insurance company or employer name:	Policy number:	Group number:
Policy holder's/employee name:	Policy holder's date of birth:	
List all household members covered under this plan:	List all household members covered under this plan:	
List all household members covered under this plan:	List all household members covered under this plan:	
List all household members covered under this plan:	List all household members covered under this plan:	

2 Children's health insurance

Skip this question and go to the next section (Unpaid medical bill information) if you are not applying for coverage for a child.

Does your health insurance cover your children? No Yes

If yes, enter child's name:

Have you dropped health insurance coverage for your children, under age 19, within the last four months? No Yes

If yes, when did the coverage end?

3 Unpaid medical bill information

Do you or anyone you are applying for need help paying for unpaid medical bills for services received in any of the 3 months immediately before the current month? No Yes

If yes, enter individual's name:

4 Past foster care

Were any members that are now 18-25 in foster care when they turned 18? No Yes

If yes, enter individual's name:

5 Non-citizen emergency medical information

You or family member may be eligible for limited emergency coverage even if you are not eligible for other coverage because of your immigration status.

Check all boxes that apply to any non-citizen you are applying for and enter their name in the space provided:

Has been treated for an emergency medical condition this month or during the past three months:

Who: _____

Needs dialysis or cancer treatment: Who: _____

Needs anti-rejection medication as a result of an organ transplant: Who: _____

Needs nursing home, assisted living, or in-home care: Who: _____

6 Pregnancy information

Are you or anyone in your household pregnant? No Yes (Use the second line if more than one person is pregnant or had a pregnancy end.) If yes,

Enter name:	Due date:	Number expected:
Enter name:	Due date:	Number expected:

Have you or any household member on this application had a pregnancy in the previous 12 months? No Yes

(Use the second line if more than one person had a pregnancy end.) If yes,

Enter name:	Date pregnancy ended:
Enter name:	Date pregnancy ended:

7 Gross income information

This section helps us determine the amount of your household's modified adjusted gross income (MAGI). MAGI income must be used to determine if you are eligible for most health care coverage programs. Please answer the following questions for each household member you are applying for as accurately as you can. Only enter information about the type of income listed.

You will need to enter current gross monthly income (amount before deductions) information for yourself, your spouse and any minors and tax dependents regardless of age, unless the minor or tax dependent will not be required to file taxes. For more information about how to report income, visit **wahbexchange.org/how-to-report-income**

Note: American Indians/Alaska Natives (AI/AN) do not have to report any AI/AN income that the Internal Revenue Service

excludes from an AI/AN's taxable gross income. In addition, AI/ANs do not have to report certain types of income for Washington Apple Health (Medicaid) as described in WAC 182-509-0340.

Income from a job: Are you or anyone in your household currently employed? No Yes

If yes, enter the name of the person employed, name of employer, and the employee's current gross monthly amount received in wages, salaries or as tip income. Do not enter self-employment income in this section. You may choose to provide an average of your income if a change in the future is clearly indicated, for example if you work a seasonal job. Estimate a monthly amount by averaging income over a representative period of time as described in WAC 182-509-0310.

Name of person employed

Name of employer

Address of employer

City

State

Zip Code

$:

Gross (before taxes are taken out) monthly income (wages, salaries, tips, corporation, S-corporation)

Was this person offered health insurance by their employer? No Yes

If yes, list all household members offered insurance

$:

What is the lowest monthly premium this employer offered to cover only the employee?

$:

What is the lowest monthly premium this employer offered to cover your household? *

Name of person employed

Name of employer

Address of employer

City

State

Zip Code

$:

Gross (before taxes are taken out) monthly income (wages, salaries, tips, corporation, S-corporation)

Was this person offered health insurance by their employer? No Yes

If yes, list all household members offered insurance

$:

What is the lowest monthly premium this employer offered to cover only the employee?

$:

What is the lowest monthly premium this employer offered to cover your household? *

Name of person employed

Name of employer

Address of employer

City

State

Zip Code

$: _____

Gross (before taxes are taken out) monthly income (wages, salaries, tips, corporation, S-corportation)

Was this person offered health insurance by their employer? No Yes

_____

If yes, list all household members offered insurance

$: _____

What is the lowest monthly premium this employer offered to cover only the employee?

$: _____

What is the lowest monthly premium this employer offered to cover your household?*

***Provide this even if you do not plan to accept employer insurance for others in your household. Your response to these questions does not affect your Apple Health eligibility.**

Self-employment income: Are you or anyone in your household self-employed? No Yes

If yes, enter the current estimated net monthly income (profits once business expenses are paid) from self- employment. Please see page ii for allowable business expenses. You may choose to provide an average of your income if a change in the future is clearly indicated. Estimate a monthly amount by averaging income over a representative period of time as described in WAC 182-509-0370.

Name of person self-employed	Name of company (if there is one)	Net monthly income (do not enter corporation or S-corporation income here)
Name of person self-employed	Name of company (if there is one)	Net monthly income (do not enter corporation or S-corporation income here)
Name of person self-employed	Name of company (if there is one)	Net monthly income (do not enter corporation or S-corporation income here)

Social Security income: Are you or anyone in your household receiving social security income? No Yes

If yes, enter income received from Social Security Administration for retirement, disability, or survivor benefits. Do not report supplemental social security (SSI) income.

Name of person receiving social security (not SSI)	Gross monthly income
Name of person receiving social security (not SSI)	Gross monthly income
Name of person receiving social security (not SSI)	Gross monthly income

Rental income: Are you or anyone in your household receiving rental income? No Yes

If yes, enter monthly income received from renting out real estate or personal property. Enter net income, after allowable business expenses.

Name of person receiving rental income	Name of property (if there is one)	Net monthly income
Name of person receiving rental income	Name of property (if there is one)	Net monthly income
Name of person receiving rental income	Name of property (if there is one)	Net monthly income

Self-employment income: Are you or anyone you are applying for currently self-employed? No Yes

If yes, enter the current estimated net monthly income (profits once business expenses are paid) from self- employment. Please see page ii for allowable business expenses. You may choose to provide an average of your income if a change in the future is clearly indicated. Estimate a monthly amount by averaging income over a representative period of time as described in WAC 182-509-0370.

Name of person self-employed	Name of company (if there is one)	Net monthly income (do not enter corporation or S-corporation income here)
Name of person self-employed	Name of company (if there is one)	Net monthly income (do not enter corporation or S-corporation income here)
Name of person self-employed	Name of company (if there is one)	Net monthly income (do not enter corporation or S-corporation income here)

Social Security income: Are you or anyone you are applying for receiving social security income? No Yes

If yes, enter income received from Social Security Administration for retirement, disability, or survivor benefits. Do not report supplemental social security (SSI) income.

Name of person receiving social security (not SSI)	Gross monthly income
Name of person receiving social security (not SSI)	Gross monthly income
Name of person receiving social security (not SSI)	Gross monthly income

8 Other income

Do not include child support or non-pension veteran's payments. Check all that apply and tell us who gets it, how much they receive, and how often they get it.

Alimony / spousal support	Who: _____	$: _____	How often: _____
	Who: _____	$: _____	How often: _____
Annuity or pension	Who: _____	$: _____	How often: _____
	Who: _____	$: _____	How often: _____
Capital gains	Who: _____	$: _____	How often: _____
	Who: _____	$: _____	How often: _____
Dividend, stocks, or shares	Who: _____	$: _____	How often: _____
	Who: _____	$: _____	How often: _____
Farming income	Who: _____	$: _____	How often: _____
	Who: _____	$: _____	How often: _____
Foreign income	Who: _____	$: _____	How often: _____
	Who: _____	$: _____	How often: _____
Income from a trust	Who: _____	$: _____	How often: _____
	Who: _____	$: _____	How often: _____
Interest income	Who: _____	$: _____	How often: _____
	Who: _____	$: _____	How often: _____
IRA income	Who: _____	$: _____	How often: _____
	Who: _____	$: _____	How often: _____
Other taxable income	Who: _____	$: _____	How often: _____
	Who: _____	$: _____	How often: _____
Railroad retirement benefits	Who: _____	$: _____	How often: _____
	Who: _____	$: _____	How often: _____
Royalty income	Who: _____	$: _____	How often: _____
	Who: _____	$: _____	How often: _____
Taxable tribal income	Who: _____	$: _____	How often: _____
	Who: _____	$: _____	How often: _____

Unemployment benefits Who: _____ $: _____ How often: _____

Who: _____ $: _____ How often: _____

Will the members under age 19 or tax dependents on this application meet the threshold requirement to file a federal tax return this year?

_____ No Yes
Name

_____ No Yes
Name

_____ No Yes
Name

9 Deductions

These expenses can reduce the amount of income that we count for some kinds of health care coverage, just like the IRS uses them to reduce the amount of taxes you owe. If you choose not to answer, you may still qualify for free or low-cost health care coverage.

Alimony / spousal support paid out Who: _____ $: _____ How often: _____

Who: _____ $: _____ How often: _____

Certain claimable business expenses Who: _____ $: _____ How often: _____

Who: _____ $: _____ How often: _____

Educator expenses Who: _____ $: _____ How often: _____

Who: _____ $: _____ How often: _____

Health savings account contributions Who: _____ $: _____ How often: _____

Who: _____ $: _____ How often: _____

Moving costs for an official military move Who: _____ $: _____ How often: _____

Who: _____ $: _____ How often: _____

Penalty on early withdrawal of savings Who: _____ $: _____ How often: _____

Who: _____ $: _____ How often: _____

Pre-tax retirement account contributions Who: _____ $: _____ How often: _____

Who: _____ $: _____ How often: _____

Self-employment health insurance Who: _____ $: _____ How often: _____

	Who: _____	$: _____	How often: _____
Self-employment retirement plan	Who: _____	$: _____	How often: _____
	Who: _____	$: _____	How often: _____
Self-employment tax	Who: _____	$: _____	How often: _____
	Who: _____	$: _____	How often: _____
Student loan interest	Who: _____	$: _____	How often: _____
	Who: _____	$: _____	How often: _____

10 Supplemental information

Do any of the members applying for coverage need any of these services?

a. Long-term care services because you are currently living in or expect to move to a medical institution, like nursing home. No Yes

If yes, enter the name of the person: _____

Type of Facility: _____

b. An in-home caregiver? No Yes If yes, enter the name of the person: _____

c. Assisted Living care services? No Yes If yes, enter the name of the person: _____

d. Services through the Division of Developmental Disabilities? No Yes

If yes, enter the name of the person: _____

e. Hospice care? No Yes If yes, enter the name of the person: _____

f. Health care coverage because they are unable to work due to a health condition or disability? No Yes

If yes, enter the name of the person(s): _____

You may be required to complete HCA form 18-005 (hca.wa.gov/assets/free-or-low-cost/18-005.pdf) if any of the following apply:

- You are age 65 or older or on Medicare.
- You answered yes to any questions in a-f above.
- You are applying for the medically needy (MN) or the Apple Health for Workers with Disabilities (HWD) program.

11 Read carefully before signing

Disclosure of information to other state and federal agencies:

I authorize Washington Healthplanfinder to electronically verify my tax return information during the annual renewal process for up to 5 years. I understand that I am able to change my consent at any time. By checking this box, I permit tax credits to be

applied to my annual renewal without my taking further action.

No Yes

I have read or had explained to me my rights and responsibilities and received a copy of *Client Rights and Responsibilities*.

12 Declaration and signature

To apply for Washington Apple Health (Medicaid) free or low-cost coverage or tax credits to lower your insurance premium, your signature is required below.

I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.

Signature

Date